BRIAN SANDOVAL
Governor

STATE OF NEVADA

TERRY JOHNSON
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Bulletin 11-013 **October 5, 2011**

INTERNAL CLAIMS AND APPEALS, AND EXTERNAL REVIEW PROCESSES UNDER THE AFFORDABLE CARE ACT

The federal Department of Health & Human Services ("HHS") released the Interim Final Regulations ("Regulation") defining the requirements for insurers' handling of internal claims, internal appeals and the external review process required by the Affordable Care Act ("ACA"). If a state fails to adopt an external review process acceptable to the HHS, then HHS will create and administer the process in that state. Nevada, however, did adopt an appropriate external review process. The purpose of this bulletin is to outline and provide a timeline of the internal claims and appeals processes, external review processes, as well as to identify the specific forms that shall be used as referenced in AB 74, effective October 1, 2011.

Nevada addressed the HHS Regulation criteria with the enactment of Assembly Bill 74 of the 2011 Session of the Legislature. *See* Assembly Bill 74, Sections 2, 3, 8, 9, 79-118.8, 123-127 and 129-131. The Division received a letter dated July 29, 2011 from the federal Center for Consumer Information and Insurance Oversight ("CCIIO") confirming that Nevada's external review process as set forth in AB 74 meets the standards of the National Association of Insurance Commissioners' ("NAIC") parallel process and, therefore, Nevada's process will not have to be administered by HHS.

AB 74 amends Nevada's internal claims and appeals, and external review process as found under Chapter 695G of the Nevada Revised Statutes. Although the federal law does not apply to grandfathered or self funded plans, AB 74 applies to both grandfathered and non-grandfathered plans in addition to the Public Employees Benefit Plan ("PEBP").

These external review processes do not apply to a policy or certificate that provides coverage for a specific disease or accident; accidents; credit; dental; disability income; hospital indemnity; long-term care insurance; vision care; or any other limited supplemental benefit; Medicare supplement; Medicare; Medicaid; Federal Health Benefits Program; CHAMPUS; any coverage supplemental to liability insurance; workers' compensation; automobile medical payment insurance; or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

Internal Claims and Appeals/Grievance Process *(For new plan year or policy year on or after September 23, 2010)*

- The covered person has the right to appeal the denial of a claim for a covered service or if a carrier rescinds coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).
- A request for an appeal must be submitted within 180 days following receipt of an adverse benefit determination.
- The carrier must notify the covered person of their right to an internal appeal and provide information about how to begin the appeals process. The notice must also include information about how to obtain an expedited appeals process in urgent cases and contact information for the Office for Consumer Health Assistance ("OCHA").
- The notice shall be provided to covered persons when they receive their Certificate or Evidence of Coverage, at the time services are disapproved or limited, and with the written notice of an adverse determination. A copy shall *also* be attached to each policy.
- The notice must be provided in a culturally and linguistically appropriate manner.
- Individual plans are limited to one level of internal appeal. This allows the claimant to seek either external review or judicial review immediately after an adverse determination is upheld under the first level of the appeals process.
- Group plans are permitted to have a second level of internal appeals.
- Carriers must provide the covered person with a decision within 72 hours after receipt of a request of an appeal concerning the denial of a claim for urgent care, within 30 days for denials of non-urgent care not yet received, and within 30 days for denials of services already received.
- If a carrier fails to strictly adhere to all the requirements of the 2010 interim final regulations, the covered person is deemed to have exhausted the carrier's internal claims and appeals process, regardless of whether the carrier asserts that it has substantially complied, and the covered person may initiate the external review process.

External Review Process (*Effective October 1, 2011)*

- The carrier must notify covered persons in writing of their right to request an external review by OCHA. The notice shall be provided to the covered persons when they receive their Certificate or Evidence of Coverage, at the time services are disapproved or limited, and with the written notice of an adverse determination. A copy shall *also* be attached to each policy. The notice must be sent within 10 working days after the service or treatment is denied. (*See* Sec. 103 of AB 74 for specific language.)

- The Commissioner may prescribe by regulation the form and content of the notice. The notice must include the contact information for OCHA. [NAIC Appendix A – Model Notice of Appeal Rights Form] should be used.
- The carrier shall include an authorization form to allow it to disclose protected health information that complies with 45 C.F.R § 164.508. [NAIC Appendix B – Model External Review Request Form] should be used.
- The notice shall also inform the covered persons of their right to request an expedited "internal" grievance and an expedited external review simultaneously when the service or treatment is experimental or investigational and the treating physician certifies in writing that the service or treatment would be less effective if not promptly initiated.
- Notices must be provided in a culturally and linguistically appropriate manner.
- The assigned Independent Review Organization ("IRO") will determine if the covered person will be required to complete the expedited internal grievance before conducting the expedited external review.
- The covered person (which may include his or her provider or authorized representative) may request an external review if the carrier has not issued a written decision within 30 days on an internal grievance.
- In lieu of resolving an internal grievance, the carrier may submit the complaint to an IRO subject to the guidelines established by AB 74.
- The request for external review must be submitted in writing to OCHA within 4 months after notice of an adverse determination is received.

Standard External Review:

- Within 5 business days after receiving the request for external review, OCHA shall notify the covered person, carrier and other interested parties that a request for external review has been filed.
- As soon as practical, OCHA shall assign the IRO.
- Within 5 business days after receiving the assignment from OCHA identifying the IRO, the carrier shall provide all documents and materials relating to the adverse determination to the IRO.
- Within 5 days after receiving notification from OCHA and the materials from the carrier, the IRO will review the materials and notify the covered person if additional information is needed to conduct the review.
- Additional information must be provided within 5 days after receiving the request.
- The IRO shall forward a copy of the additional information to the carrier within 1 business day after receipt.
- Within 15 days of completing the review, the IRO shall submit a copy of its determination to the covered person.

Expedited External Review:

- OCHA shall approve or deny a request for an expedited external review within 72 hours after it receives proof from the covered person's provider of health care that the adverse determination concerns:

        - an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from the facility providing the care; or
        - failure to proceed in an expedited manner may jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.
    - Upon determination that the request is eligible for an expedited external review, OCHA shall assign an IRO within 1 working day after approving the request.
    - The carrier shall provide all documents and information used to make the adverse determination to the IRO within 24 hours after receiving notice from OCHA assigning the request.
    - The IRO must complete its review within 48 hours (unless the covered person and health carrier agree to a longer period) after receiving the assignment.
    - Within 24 hours after completing the assignment, the IRO must notify the covered person, physician and health carrier of its determination by telephone, followed up in writing within 48 hours.

- If the determination of the IRO is in favor of the covered person: the determination is final, conclusive and binding.
- An IRO or clinical peer is not liable in a civil action for damages relating to the determination made by the IRO if the determination is made in good faith and without gross negligence.
- The cost of conducting the external review must be paid by the carrier that made the adverse determination.

Request for External Review Due to Denial of Experimental or Investigational Treatment:

- The health carrier must notify the covered persons in writing of their right to submit a request for an external review to OCHA.
- The request for external review must be submitted in writing to OCHA within 4 months after notice of an adverse determination is received.

  Standard External Review:

    - OCHA will notify the carrier within 1 business day after receipt of a request for external review.
    - The carrier shall make a preliminary determination of eligibility within 5 business days of receipt of the request from OCHA.
    - Within 1 business day after completion, the carrier will notify OCHA and the covered person in writing whether the request is complete and eligible for review.
    - The Commissioner may specify the form for the notice of initial determination and any supporting information to be included in the notice. The notice must include a statement that a request that is determined to be ineligible for external review may be appealed to OCHA. OCHA can overturn a carrier's determination that the request is ineligible.
    - The carrier shall notify OCHA and the covered person once it determines that a request is eligible for external review.

- Within 1 business day after receiving notice from the carrier, OCHA will assign the IRO and notify the carrier the name of the IRO. OCHA will also notify the covered person in writing that the request is eligible and provide the name of the IRO.

Expedited External Review:

- An ORAL request may be made if the treating physician certifies in writing that the treatment would be significantly less effective if not promptly initiated.
- Upon receipt, OCHA shall immediately notify the carrier.
- The carrier will immediately determine if the request meets the requirements for review. The carrier will then immediately notify OCHA and the covered person of its determination.
- The Commissioner may specify the form for the notice of initial determination and any supporting information that is to be included in the notice. The notice must include a statement that a request that is determined to be ineligible for expedited external review may be appealed to OCHA. OCHA can <u>overturn</u> a carrier's determination that the request is ineligible.
- OCHA will immediately assign an IRO to conduct the expedited external review.
- The carrier shall expeditiously transmit any documentation used in making their determination to the IRO.

- The covered person may within 5 business days after receiving the IRO notice, submit in writing to the IRO any additional information.
- Any information submitted to the IRO by the covered person after the 5 business days has passed, **MAY** be considered as well.
- The IRO must select one or more clinical reviewers within 1 business day after receipt of assignment. The carrier has 5 business days to submit documentation used in the adverse determination to the assigned IRO.
- If the carrier fails to provide the information within the specified time, the IRO may terminate the review and reverse the adverse determination. The IRO must notify the carrier, the covered person and OCHA of its decision to do so.
- The IRO has 1 business day after receipt of any information received from the covered person to submit it to the carrier.
- Upon receipt of the information, the carrier may reconsider its original determination *or* terminate the review and immediately provide coverage for the service. The carrier must notify the IRO, the covered person and OCHA of its decision to do so.
- Each clinical reviewer shall provide a written opinion to the IRO within 20 days. If it is an expedited review, it may be provided orally or in writing to the IRO, but in no event in more than 5 calendar days. If the opinion is provided orally, then the written opinion is required within 48 hours following the date opinion provided to the IRO.
- If it is not an expedited review, the IRO has 20 days to review the opinion of each of the clinical reviewers.
- If it is an expedited review, the IRO has 48 hours to review the opinion of the clinical reviewers.
- If the opinions are equally split, the IRO shall seek another opinion to break the tie.

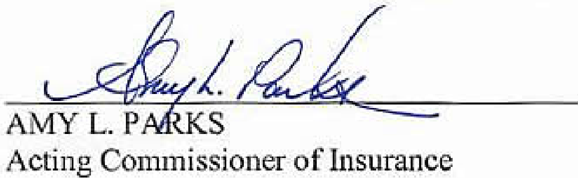
- The carrier shall immediately approve the coverage or recommended treatment upon receipt of the notice reversing the adverse determination.

Reporting:

- The IRO must maintain written records on all requests for an external review conducted during a calendar year for at least 3 years, aggregated for each state and for each health carrier; and, upon request, submit a report to OCHA in a format specified by the Commissioner. (*See* Sec. 110.) NAIC Appendix C – Independent Review Organization External Review Annual Reporting Form should be used.

- Each health carrier shall maintain written records on all requests for external review for at least 3 years, aggregated for each state, and submit a report of the data for the prior calendar year to OCHA in a format specified by the Commissioner. The report shall be submitted on or before December 31 of each year. (*See* Sec. 110 and 118.8.) NAIC Model Appendix D – Model Health Carrier External Review Annual Reporting Form should be used.

Please direct any questions to the Division's Life and Health Section in Carson City Nevada, (775) 687-0700 or by using the Division's toll free number at (888) 872-3234.


This bulletin becomes effective October 5, 2011

AMY L. PARKS
Acting Commissioner of Insurance

Appendix A – Model Notice of Appeal Rights

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request additional explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact[1] us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Evidence of Coverage or Certificate of Coverage;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.[1]

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to *[insert address of where appeals should be sent to the health carrier]* within **180 days** of the date you receive our denial.[2] We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing within **30 days** of receiving your appeal. If you do not receive our decision within **30 days** of receiving your appeal, you are entitled to file a request for external review.

External Review: If we have denied your request for the provision of or payment for a health care service or course of treatment, you may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review within **4 months** after receipt of this notice to the Office for Consumer Health Assistance, 555 East Washington #4800 Las Vegas NV 89101, Phone: (702) 486-3587, (888) 333-1597, or Fax 702-486-3586, Web: www.govcha.nv.gov. For standard external review, a decision will be made **within 45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial. For details, please review your Evidence of Coverage or Certificate of Coverage, contact us, the Office for Consumer Health Assistance or contact the Nevada Division of Insurance.

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[1] See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.
[2] Unless your plan or any applicable state law allows you additional time.

Appendix B – Model External Review Request Form

This **EXTERNAL REVIEW REQUEST FORM** must be filed with Office for Consumer Health Assistance within **FOUR (4) MONTHS** after receipt from your insurer/HMO of a denial of payment on a claim or request for coverage of a health care service or treatment.

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME ______________________________

☐Covered person/Patient ☐ Provider☐ Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: ____________________________________

Patient Name: _____________________________________

Address:

____

____

Covered Person Phone #: Home (______) ________________________

Work (______) ____

INSURANCE INFORMATION

Insurer/HMO
Name: ____

Covered Person Insurance ID#:

____

Insurance Claim/Reference
#: ____

Insurer/HMO Mailing Address:

____

____

Insurer Telephone
#: (_____)____

EMPLOYER INFORMATION

Employer's Name:

____

Employer's Phone
#: (_____)____

Is the health coverage you have through your employer a self-funded plan? ________. If you are not certain please check with your employer. Some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider:

____

Address:

____

____

____

Contact Person: ____

Phone: ( ) ______________________________________

Medical Record #:__________________________________

REASON FOR HEALTH CARRIER DENIAL (Please check one)

- ☐ The health care service or treatment is not medically necessary.
- ☐ The health care service or treatment is experimental or investigational.

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)*

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*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using the attached pages below.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? Yes ________ No _________

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _______________________________, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Office for Consumer Health Assistance. I understand that the independent review organization and the Office for Consumer Health Assistance will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

____ ______________

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other – Please Specify)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize ___________________________________ to pursue my appeal on my behalf.

____ __________________

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative:

____

____

Phone #: Daytime (_______) __________________________

Evening (________) _________________________________

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

DESCRIBE IN YOUR OWN WORDS THE DISAGREEMENT WITH YOUR HEALTH CARRIER. INDICATE CLEARLY THE SERVICE(S) BEING DENIED AND THE SPECIFIC DATE(S) BEING DENIED. EXPLAIN WHY YOU DISAGREE. ATTACH ADDITIONAL PAGES IF NECESSARY AND INCLUDE AVAILABLE PERTINENT MEDICAL RECORDS, ANY INFORMATION YOU RECEIVED FROM YOUR HEALTH CARRIER CONCERNING THE DENIAL, ANY PERTINENT PEER LITERATURE OR CLINICAL STUDIES, AND ANY ADDITIONAL INFORMATION FROM YOUR PHYSICIAN/HEALTH CARE PROVIDER THAT YOU WANT THE INDEPENDENT REVIEW ORGANIZATION REVIEWER TO CONSIDER.

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WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. ☐ **YES**, I have included this completed application form signed and dated.

2. ☐ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;

3. ☐ **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
   (a) Their decision is final and that I have exhausted all internal review procedures; or
   (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Office for Consumer Health Assistance, 555 East Washington #4800 Las Vegas NV 89101, Phone: (702) 486-3587, (888) 333-1597, or Fax 702-486-3586, Web: www.govcha.nv.gov.

4. ☐ **YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

*Call the Office for Consumer Health Assistance at (702) 486-3587 or (888) 333-1597 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to: Office for Consumer Health Assistance, 555 East Washington #4800 Las Vegas NV 89101.

If you are requesting an expedited external review, call the Office for Consumer Health Assistance at (702) 486-3587 or (888) 333-1597 before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

CERTIFICATION OF TREATING HEALTH CARE PROVIDER FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW APPEAL

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Office for Consumer Health Assistance oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our department. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION:

Name of Treating Health Care Provider:

____

Mailing Address:

____

____

Phone Number: (_____) ______________________________

Fax Number: (_____) ______________________________

Licensure and Area of Clinical Specialty:

____

____

Name of Patient:

____

Patient's Insurer Member ID#: ___________________________________

CERTIFICATION:

I hereby certify that: I am a treating health care provider for

____

(hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

____

Treating Health Care Provider's Name (Please Print)

____ ________________________

Signature Date

PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for __________________ (covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

In my medical opinion as the Insured's treating physician, I hereby certify to the following:
(Please check all that apply) (**NOTE:** Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

☐ 1) The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

☐ 2) The covered person has a condition that qualifies under one or more of the following: [please indicate which description(s) apply]:

☐ Standard health care services or treatments have not been effective in improving the covered person's condition;

☐ Standard health care services or treatments are not medically appropriate for the covered person; or

☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

☐ 3) The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

☐ 4) The health care service or treatment recommended would be significantly less effective if not promptly initiated.

Explain:____

____

____

☐ 5) It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.
Explain:

____

____

____

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional sheets as necessary)

____

____

____

____ ________________________
Physician's Signature Date

Appendix C – Independent Review Organization External Review Annual Report Form

Independent Review Organization External Review Annual Report Form

External Review Annual Summary for 20___ Due on December 31 for previous calendar year.	
Each independent review organization (IRO) shall submit an annual report with information for each health carrier in the aggregate on external reviews performed in Nevada only.	
1. IRO name:	Filing date:
2. IRO license/certification no:	
3. IRO address:	
City, State, ZIP:	
4. IRO Web site:	
5. Name, email address, phone and fax number of the person completing this form:	
6. Name and title of the person responsible for regulatory compliance and quality of external reviews:	
Name:	Title:
7. Total number of requests for external review received from Office for Consumer Health Assistance during the reporting period:	
8. Number of standard external reviews:	
9. Average number of days IRO required to reach a final decision in standard reviews:	
10. Number of expedited reviews completed to a final decision:	
11. Average number of days IRO required to reach a final decision in expedited reviews:	

12. Number of medical necessity reviews decided in favor of the health carrier:

Briefly list procedures denied:	______ ______ ______ ______

13. Number of medical necessity reviews decided in favor of the covered person:

Briefly list procedures approved:	______ ______ ______ ______

14. Number of experimental/investigational reviews decided in favor of the health carrier:

Briefly list procedures denied:	______ ______ ______ ______

15. Number of experimental/investigational reviews decided in favor of the covered person:

Briefly list procedures approved:	______ ______ ______ ______

16. Number of reviews terminated as the result of a reconsideration by the health carrier:

17. Number of reviews terminated by the covered person:					
18. Number of reviews declined due to possible conflict with:					
Health carrier		Covered person		Health care provider	
Describe possible conflicts(s) of interest:	____________________ ____________________ ____________________ ____________________				
19. Number of reviews declined due to other reasons not reflected in #18 above:					

Appendix D – Model Health Carrier External Review Annual Report Form

Health Carrier External Review Annual Report Form

External Review Annual Summary for 20___ **Due on December 31 for previous calendar year.**	
Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.	
1. Health carrier name:	Filing Date:
2. Health carrier address:	
City, State, ZIP:	
3. Health carrier Web site:	
4. Name, email address, phone and fax number of the person completing this form:	
5. Total number of external review requests received from Office for Consumer Health Assistance during the reporting period:	
6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review:	